DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	05/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 5/22/06 through 5/25/06. The census at the time of the survey was 176. The sample size was 27. Six complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. 1. Complaint #NV00011709 was a self-reported incident of an altercation between two residents. The incident did occur with no deficiencies cited. 2. Complaint #NV00011908 was a self-reported incident of a resident falling from bed and sustaining a head laceration. The incident did occur with no regulatory deficiencies cited. 3. Complaint #NV00011538 was an entity-reported incident of an altercation from one resident upon another resident. The incident was substantiated but no deficiency was cited based on the facility's actions. 4. Complaint # NV00011078 was a self reported incident of an injury of unknown origin. The event was substantiated. No deficiencies were cited based on the facility's actions. 5. Complaint #NV00011707 was a self reported incident of a resident to resident event. The event did occur with no deficiencies cited based on the facility's actions.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. RECEIVED JUN 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Panziola | TITLE: Administrator | (X6) DATE: 6/19/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 6. Complaint #NV00011790 was a self reported incident of a resident to resident event. The event did occur with no deficiencies cited based on the facility's actions.	F 000	F 156 The facility does and will continue to provide written information on advance directives and will document that the resident and/or responsible party has received this information on advance directives. • Social Services will provide written information on advance directives to those residents identified in the sample, and will document that the resident and/or responsible party has received this information. • Charts of current residents will be audited by Social Services to assure appropriate documentation is in place. New admissions will be provided with information on Advance Directives at the time of admission. • The facility has obtained a copy of the "Nevada Limited Treatment Policy". Social Services staff will receive training by a corporate Social Service Consultant on this policy. Social Services will complete an Advance Directive worksheet from the Social Services Manual on residents charts to ensure documentation is in place.	7/9/06
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

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F 156	Continued From page 2 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156	• Social Services will complete the "Advance Directive Audit Tool" from the QAA manual on new admits monthly for six months and then quarterly thereafter. The findings will be submitted to the QAA committee for further recommendations and validation.	7/9/06

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F 156	Continued From page 3 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide written information on advanced directives on each admission to the facility and to document that the resident had received such information for 27 of 27 residents in the sample. Findings include: A review of the medical records for Residents #1 through #27 revealed that there was no acknowledgement that the residents received information on advanced directives. An interview with the social worker and the admission coordinator revealed that written information on	F 156		

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F 156	Continued From page 4 advanced directives was not provided in the admission paperwork nor was a signed statement obtained from the resident or responsible party indicating that advanced directive information was provided. The records that contained an advanced directive were all initiated prior to admission to the facility. Specific examples are as follows: Resident #8: Resident #8 was admitted to the facility on 1/12/06 with diagnoses including multiple sclerosis, diabetes, paraplegia, neurogenic bladder, and depression. Record review of 5/22/06 revealed no evidence that the resident had received information on advanced directives. The social worker was interviewed on 5/22/06 and was unable to provide documentation indicating that the resident had received information on advanced directives. Resident #9: Resident #9 was admitted to the facility on 4/18/06 with diagnoses including metastatic lung cancer, fracture of the right hip, chronic obstructive pulmonary disease and osteoporosis. Record review of 5/22/06 revealed no evidence that the resident had received information on advanced directives. Resident #22: Resident #22 was admitted to the facility on 5/13/06 with diagnoses including cerebrovascular accident, malleolar fracture, and osteomyelitis. Record review of 5/23/06 revealed no evidence that the resident had received information on advanced directives. Resident #23: Resident #23 was admitted to the facility on 5/16/06 with diagnoses including senile dementia, left femoral neck fracture and benign	F 156		

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F 156	Continued From page 5 prostatic hypertrophy. Record review of 5/24/06 revealed no evidence that the resident had received information on advanced directives. Resident #10: The resident was admitted to the facility on 6/16/03. The resident's diagnoses included cerebral vascular accident with right hemiparesis, diabetes, bipolar disorder and epilepsy. A review of the resident's record failed to reveal evidence of an acknowledgement of advanced directives form. Resident #11: The resident was admitted to the facility on 8/2/04. The resident's readmission date was on 3/16/05. The resident's diagnoses included post surgical right total hip replacement, hypertension, and seizure disorder. A review of the resident's record failed to reveal evidence of an acknowledgement of advanced directives form. Resident #24: The resident was admitted to the facility on 5/12/06. The resident's diagnoses included respiratory failure, chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation, and hypertension. A review of the resident's record failed to reveal evidence of an acknowledgement of advanced directives form. Resident #25: The resident was admitted to the facility on 8/26/04. The resident was readmitted to the facility on 7/25/05. The resident's diagnoses included congestive heart failure, hypertension, depression with anxiety, and osteoporosis. A review of the resident's record failed to reveal evidence of an acknowledgement of advanced directives form.	F 156		
F 222	483.13(a) CHEMICAL RESTRAINTS	F 222		

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F 222 SS=E	Continued From page 6 The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined that the facility failed to obtain consent for the use of chemical restraints from the resident or their legal representative for 5 of 27 residents. (Residents #23, #22, #9, #25, #7) In addition, the facility failed to monitor the response to the chemical restraint for 1 out of 27 residents. (Resident #23) Findings include: Resident #23: The resident was admitted to the facility on 5/16/06 with diagnoses including senile dementia and left femoral neck fracture. Record review on 5/24/06 revealed that the resident was experiencing episodes of agitation and combativeness. On 5/17/06 the resident was ordered Haldol as needed with consent obtained from the resident's wife on 5/18/06. The resident was ordered Depakote for combativeness and delusions on 5/22/06. The resident's record revealed no evidence that consent for use of Depakote had been obtained from the residents wife. No evidence of behavioral monitoring was found in the resident record to assess his response to the medication. On 5/24/06 an interview with the LPN (Licensed Practical Nurse) who was supervising the unit,	F 222	F222 The facility does and will continue to obtain a consent for the use of chemical restrains from the resident or their legal representative. • Consents have been obtained or the chemical restraint has been discontinued for residents # 23, # 22, and # 25. Residents # 7 and # 9 have been discharged. A behavior monitoring record was initiated for resident # 23. Resident # 7 discharged home with granddaughter. • Charts have been audited to identify those residents receiving chemical restraints and consents have been obtained for these medications. * Those residents receiving chemical restraints related to behavioral problems will have ongoing behavior monitoring completed as part of their plan of care utilizing the behavior monitoring tracking form.	6/19/06 6/19/06 7/9/06

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F 222	Continued From page 7 revealed that a behavioral tracking tool was to be utilized when a resident was receiving psychotropic medications. She was unable to find a behavioral tracking tool for Resident #23 after reviewing his record. Resident #22: The resident was admitted to the facility on 5/13/06 with diagnoses including cerebrovascular accident, malleolar fracture, osteomyelitis, anxiety and depression. On admission, an order for Seroquel, an antipsychotic, was written. Record review on 5/24/06, revealed no evidence that consent had been obtained for the use of Seroquel. Resident #9: The resident was admitted to the facility on 4/18/06 with diagnoses including right hip fracture, osteoporosis, metastatic carcinoma and chronic obstructive pulmonary disease. On 4/30/06, Ativan was ordered for anxiety. On 5/22/06, record review revealed no evidence that informed consent was obtained from the resident prior to initiation of the drug. The DON (Director of Nurses) was interviewed on 5/24/06 and provided the facility's policy which indicated that the behavioral tracking form was to be used for monitoring behaviors of residents receiving psychotropic medications. The DON reported that she could not find a facility policy addressing the need to obtain consent for the use of psychotropic drugs. Resident #25: The resident was admitted to the facility on 8/26/04. The resident was readmitted to the facility on 7/25/05. The resident's diagnoses included congestive heart failure, hypertension, depression with anxiety, and osteoporosis. A review of the psychiatrist's progress notes revealed that the resident was on	F 222	• The Director of Nursing or designee will audit telephone orders for chemical restraints. The DON or designee will ensure that consents have been obtained for these medications. The DON or designee will monitor to assure behavior tracking is in place. Licensed nurses will be re-educated regarding the guidelines for use of chemical restraints and obtaining consents from the appropriate party. • The DON or designee will complete the QAA audit tool for behavior monitoring and psychotropic guidelines meeting this criteria and return findings to the QAA committee quarterly for further recommendations as needed.	7/9/06 7/9/06

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F 222	Continued From page 8 Depakote "to augment against anxiety." There was no evidence found in the resident's record that informed consent was obtained for the Depakote. Resident #7: The resident was a 90 year old female admitted to the facility on 05/11/06 with diagnoses of debility, urinary tract infection, malaise and fatigue and with a history of falls. The resident was legally blind. She was also alert and oriented. It was revealed during an interview with the resident on 5/22/06 at 10:00 AM that she made her own health care decisions and that her granddaughter who lived in Alabama would assist her in carrying out those decisions. Record review revealed that Resident #7 was prescribed Ativan, an antianxiety medication. This medication was ordered for the resident following an attempted elopement by the resident close to the time of her admission to the facility. During the resident record review it was noted that a consent for Ativan had not been signed by either the resident or her granddaughter. There was a written notation on the consent that verbal consent had been obtained from the granddaughter on 05/15/06 although the resident was able to make her own medical decisions. Review of the medication administration record in the resident record revealed that the resident had received several doses of the medication since admission. Further investigation into the resident record revealed no power of attorney documentation that supported the facility action of asking the granddaughter to make decisions for the resident.	F 222		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a	F 241		

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F 241	Continued From page 9 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident interview and observation it was determined that the facility failed to ensure that all staff responded to residents in a dignified manner. Findings include: During the group interview on 5/23/06, one resident complained that when she approached some staff members with a question, she was ignored and if she repeated the question the staff member would say "I heard you," but would not answer the question. During a general observation of the facility at approximately 10:00 AM on 5/22/06, it was observed on the Wellington Hall that a female resident, in a wheelchair, was in front of the nurses' station. A female staff member, with an identification badge showing that she was with Social Services, was working on a resident's chart. The resident stated that she "needed to see my doctor." The staff person did not acknowledge the resident. The resident again stated in a louder voice, "I need to see my doctor." Again the staff person did not acknowledge the resident. When the resident began screaming "I need to see my doctor," the staff person stated, "I can't do anything about it." A nurse then came rushing over to the resident speaking to her in a soothing voice, stating that she would see what she could do to help her.	F 241	F 241 The facility does and will continue to ensure staff responds to residents in a dignified manner. • The resident's request was acknowledged by the nurse at the station on 5/23/06 • Residents approaching the nurses station for assistance will be responded to in a timely and respectful manner. • This facility does and will continue to require that staff members complete abuse and neglect prevention training upon hire and annually thereafter and are aware of the requirement for treating the residents with dignity. • Human Resources will audit employee files to ensure compliance with abuse and neglect prevention training. Counseling and additional training will be provided when problems are identified. RECEIVED JUN 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	6/19/06 7/9/06 7/9/06 7/9/06

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F 246	Continued From page 10	F 246		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that 1 of 27 residents had a call light accessible at all times. (Resident #2) Findings include: Resident #2: The resident was admitted to the facility on 11/28/05 with diagnoses including acetabular fracture, hypothyroidism, seizure disorder, and hypertension. Resident #2 had experienced three recent falls all requiring sutures to the forehead. The resident had fallen out of bed, out of her wheelchair, and out of a regular chair. The resident was observed sitting in her wheelchair at lunch on 5/22/06 next to her bed. Her call light was out of her reach, located on the opposite side of the bed. The surveyor placed the call light within her reach and exited the room. Approximately one hour later, a second surveyor entered the resident's room to interview the resident. The resident was seated in her wheelchair near the foot of her bed on one side of the bed. The resident's call light was coiled and hanging on the wall at the head of her bed and not within reach. The resident indicated	F 246	F 246 The facility does and will continue to ensure that call lights are accessible to residents. • The care plan for resident # 2 was reviewed and does include the statement "call light to be accessible when resident in room". 6/19/06 • Residents in their rooms will continue to have the call light available. 6/19/06 • This facility does and will continue to educate new staff members upon hire of the requirement of having the call light accessible to the resident. 7/9/06 Licensed nurses will observe for call light placement during rounds and correct placement if needed. • Random checks will be conducted daily during rounds by the DON and Administrator. Problems identified will be resolved immediately and trends identified will be brought to the QAA committee for further recommendations. 7/9/06	

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F 246	Continued From page 11 that someone had recently made her bed and moved the call light. The surveyor placed the call light within the resident's reach.	F 246	F 250 The facility does and will continue to provide Social Service interventions or follow-up discharge planning to address and maintain the psychosocial well-being for the residents of the facility.	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide social service interventions or follow up discharge planning to address and maintain the psychosocial well-being for 1 of 27 residents. (Resident #3) Findings include: Resident #3: The resident was admitted to the facility on 3/22/05 from an acute care facility. The discharge summary from the acute care facility indicated that the resident had progressive weakness and falls at home. It also indicated that the resident's condition of weakness and confusion limited his rehabilitation candidacy and that his wife was unable to care for him at home. Record review revealed a form used by the facility entitled "Discharge Plan." Instructions were to include the resident's discharge intent, assessment of discharge potential, and treatment and services needed to be provided for a successful discharge. The form was also to be	F 250	• Licensed Social Worker met with Resident # 3 to discuss discharge options. Resident is aware and approves of the need for long term placement in the facility. Resident # 3 care plan updated with an approach "to praise for appropriate behavior". A new care plan was initiated for "potential for decreased mood due to resident's choice to be bedfast". • Social Services will audit resident charts to assess discharge plans for like residents in the same situation. • Social Services will review discharge plans quarterly during care conference. Social Services will invite the resident to attend care conference, in addition to the responsible party. The plan of care will be reviewed and documented for any resident that is unable to attend care conference.	6/13/06 6/13/06 7/9/06 7/9/06 7/9/06

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 12 updated to show changes in the discharge plan. An entry on 3/29/05 was made seven days after the resident was admitted. The entry documented that the resident wanted to go home, but needed to improve with physical therapy ambulation so that the resident's spouse could care for him at home. This entry also indicated that the resident would remain on long term care due to need for 24 hour care and supervision. This entry was written by social service. There was no further entries on this form regarding the discharge plan. The back of this form indicated that case conferences were held approximately every three months. There was no indication that the resident attended any of these care plan meetings although the spouse did. An interview with social worker on 5/25/06 revealed that there was no further entry regarding the discharge plan because the plan of long term care had not changed from the initial note entered seven days after admission. The social service staff could not provide any documentation that the resident was informed that his spouse could not take him home and that his stay was long term, as of seven days into his stay at the facility. Documentation in the therapy notes indicated that the resident refused therapy sessions and was fearful of using the slide board to transfer out of bed when last attempted in November of 2005. Activities documented that the resident was room bound and bed bound by choice. Care plans indicated that the resident was non-compliant with	F 250	Resident monitoring tracking form will be reinstated in order to monitor resident's mood and non-compliant behaviors. Additional education will be provided to Social Services regarding behavior management guidelines by the corporate Social Service Consultant. • Social Services will review documentation for residents on behavior monitoring. Social Services will provide and document, positive feedback when appropriate. Social Worker will complete the QAA audit tool for behavior on residents meeting the criteria and return findings to the QAA Committee monthly. Areas that require follow-up will be reviewed during stand up. RECEIVED JUN 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	7/9/06 7/9/06

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F 250	Continued From page 13 care. The clinical record contained an entry that in October 2005, the administrator conference with the resident related to behaviors that the staff perceived as inappropriate. The facility could not provide any social service documentation that behaviors identified by the facility, as non-compliant, were addressed on an ongoing basis, with positive feedback to the resident when he did participate. There was also no evidence that the resident's behaviors did not alienate staff causing a decline of the resident's physical, mental and psychosocial well-being.	F 250		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272		

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F 272	Continued From page 14 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to assess a resident prior to administering a tuberculin skin test for 1 of 27 residents. (Resident #10) Findings include: Resident #10: The resident was admitted to the facility on 6/16/03. The resident's diagnoses included cerebral vascular accident with right hemiparesis, diabetes, bipolar disorder and epilepsy. A review of the resident's record revealed that the resident had a history of a positive tuberculin skin test. A history of a positive tuberculin skin test is a contraindication to receiving the skin test. The standard of practice is to assess a person for a history of a positive tuberculin skin test prior to administering a two step skin test or an annual one step skin test. A review of the nurse's notes dated on 5/23/06, revealed that the skin test was given to the resident on her left forearm. It was documented that the area was red and indurated. A review of the physician's orders dated on 5/23/06, revealed an order that the tuberculin skin tests be discontinued, that annual chest x-rays be ordered, that a medicated cream be applied three	F 272	F 272 This facility does and will continue to assess residents prior to administering a tuberculin skin test. • Resident # 10 received appropriate nursing care for reaction to TB skin test. Her medical record has been updated and an order written indicating no further TB skin testing. • Charts will be audited for contraindications to receiving a TB skin test. • Historical information on each resident will be transcribed to the new "Immunization form" and inserted into the MAR (Medication Administration Record). • DON or designee will audit new admission charts to ensure that correct documentation and instructions are in place. RECEIVED JUN 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	6/19/06 6/19/06 7/9/06 7/9/06

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F 272	Continued From page 15 times a day, and that the area be covered with a dry dressing for five days.	F 272		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to accurately project the assessment by physical therapy and	F 278	F 278 The facility does and will continue to accurately complete the MDS as required. • MDS nurse will complete a significant correction assessment for Resident # 3. • Residents will continue to be assessed and results of the assessment recorded in the MDS for current and future residents. • MDS nurses will be instructed to review pertinent records, including therapy assessments prior to completing the MDS. • The DON or designee will conduct random review of selected MDS's for accuracy. Problems identified, if any, will be corrected, trended and reported to QAA.	7/9/06 7/9/06 7/9/06 7/9/06

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F 278	Continued From page 16 nursing to the MDS (Minimum Data Set) for 1 of 27 residents. (Resident #3) Findings include: Resident #3: The resident was admitted to the facility on 3/22/05 from an acute care facility. The discharge summary indicated that the resident had progressive weakness and falls at home. An interview with a physical therapist on 5/25/06 revealed that the resident had bilateral contractures to his knees which prevented him from being able to do any kind of straight leg posturing. The therapist stated that the contractures would have prevented him from standing upright and possibly even sitting in a chair. Record review revealed that an annual MDS assessment performed on 3/23/06 identified no limitation or loss of range of motion or voluntary movement to any extremities: neck, arm, hand, leg, foot or other limitations or loss. The facility could not provide any documentation why the MDS differed from the therapist's assessment.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		

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F 279	Continued From page 17 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident record review and staff interview, it was determined that the facility failed to develop, review and revise the comprehensive careplans for 3 of 27 residents. (Residents #10, #12 and #4) Findings include: Resident #10: The resident was admitted to the facility on 6/16/03. The resident's diagnoses included cerebral vascular accident with right hemiparesis, diabetes, bipolar disorder and epilepsy. A review of the resident's record revealed that the resident had a dental exam on 1/24/06. It was documented in the dental exam notes that the resident's oral hygiene was poor and that it needed to be improved. A review of the nursing summary had a check mark by "daily cleaning of teeth by resident or staff." The staff interviewed stated that oral care was part of the facility's standard of practice. On 5/22/06, there was a care plan implemented for dental/mouth problems. There was no evidence in the care plan that specified how this level of care would be	F 279	F 279 The facility does and will continue to develop, review and revise the comprehensive care plan for the residents of the facility. • A new care plan has been initiated for Resident # 10. Resident # 12 has been discharged from the facility. The care plan for Resident # 4 has been updated. • A resident identified with a change in condition will have care plan review and revision as needed. • Licensed nurses have been re-educated to recognize a resident with a change in condition or care need and review and revise the care plan as needed. • The DON or designee will conduct random audits to ensure that care plans are reflective of residents needs. Corrections are made as needed and report trends to QAA committee.	6/19/06 6/19/06 6/19/06 7/9/06 7/9/06 7/9/06

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F 279	Continued From page 18 improved, such as by more frequent teeth cleanings, adding the use of dental floss or consulting with the dentist regarding the use of a plaque fighting mouth rinse, if appropriate, or increased frequency of dental cleanings. In summary, Resident #10 had been in the facility since 6/16/03, receiving the facility's oral hygiene standard of care. On 1/24/06, it was determined that the resident needed improved oral hygiene. A care plan was implemented on 5/22/06. There was no evidence found in the care plan that the resident's oral hygiene plan of care was improved upon compared to the facility's oral hygiene standard of care. Resident # 12: The resident was readmitted to the facility on 3/30/06. She had been in an acute care facility. Her original admission was 3/10/06, also following an acute care stay. Diagnoses included deep vein thrombosis, colitis, hypertension, anxiety and a clostridium difficile infection. The resident had a Foley catheter with orders to discontinue it on 4/3/06. When the catheter was discontinued, there was no evidence that the facility's pre developed care plan for removal of an indwelling catheter was utilized or adapted for this resident. By not having a care plan, they failed to develop objectives and to establish timetables that would have met her individual needs. Cross reference to Tag F315. Resident #4: The resident was admitted to facility on 10/14/04 with the diagnoses of failure to thrive and dementia and a wound on the right knee. On 5/24/06 an interview was conducted with a licensed staff member regarding Resident #4's wound care management, assessments and	F 279		

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F 279	Continued From page 19 careplan interventions. The care plan for resident only had "wound care as ordered" and no dates of interventions or changes to the plan. The licensed staff member was asked why the care plans had no documentation as to what the specific wound care was or changes/alterations to the wound care and the dates of these alterations to document progression of wound interventions. The staff member stated that "the care plans are purposely vague because then the staff will be following the care plans."	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to follow the physicians orders for treatment and/or medications for 3 or 27 residents. (Residents #27, #13, and #24) Findings include: Resident #27: The resident was admitted to the facility on 1/26/05 and was discharged on 5/15/06. a review of this closed record revealed that the resident had diagnoses of cellulitis, obesity, deep vein thrombosis, hypertension, osteoporosis and depression.	F 309		

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F 309	Continued From page 20 A review of the physician's orders disclosed an order to discontinue the Foley catheter and to send a specimen for an urinalysis and culture and sensitivity. The order was written on 2/28/06. A review of the nurses notes for 2/28/06 show that the "Foley was to be removed in the AM after obtaining the urine specimen." The order did not state to remove the catheter in the AM. On 3/1/06, another order was written that read "remove the Foley cath as per order 2/28/06. Send urinalysis and culture and sensitivity." The nurse's notes for that day stated that the Foley was to dependent drainage and was patent for Resident #27. On 3/2/06, a new physician's order read stated "please complete indwelling catheter removal." The nurses notes for 3/2/06 revealed that Resident #27's Foley was discontinued, three days after the original order was written. Resident #13: The resident was admitted to the facility on 4/04/06. Diagnoses included renal disease, chronic obstructive pulmonary disease, diabetes, and hypertension. On admission, an order was written for Prednisone 20 mg by mouth daily, then taper. The medication was given at 20 mg per day for thirteen days. There was no evidence that any attempt had been made to clarify what was indicated by "tapering." Resident #24: The resident was admitted to the facility on 5/12/06. The resident was admitted from a hospital. The discharge plans included	F 309	F 309 The facility does and will continue to follow the physician's orders for treatment and or medications for all the residents. • Resident # 27 has been discharged to an assisted living facility. Orders for Resident # 13 have been reviewed and clarified with the physician. Resident # 24 has been discharged from the facility. • Residents receiving a physician order can be assured that if the order is unclear it will be clarified,other wise will be followed as written in a timely manner. • The DON or designee will review telephone orders daily. Problems, if any, are identified and delegated to nurse managers to ensure compliance with physician orders. • Problems identified as trends are brought to the QAA committee for further resolution.	6/19/06 7/9/06 7/9/06 7/9/06

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F 309	Continued From page 21 oxygen at five liters per minute. The resident's diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure, atrial fibrillation, and hypertension. A review of Resident #24's record revealed that there was no physician's order for oxygen or for pulse oxymetry readings. The director of nursing (DON) was unable to find an order for these items in the resident's record. The record revealed that between 5/12/06 and 5/20/06 the resident was on oxygen. The record revealed that the resident's oxygen saturations were being measured. The record revealed that the resident's oxygen saturations were between 84% and 95% during this time period. The record revealed that the resident's oxygen was being titrated between three liters and five liters of oxygen. In summary, there was no guidance from physician's orders on when to check oxygen saturations or at what levels to titrate Resident #24's oxygen.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined that the facility failed to reassess the need for a Foley catheter following wound healing for 1 of 27 residents (Resident #20) and failed to assess a resident's toileting needs following the removal of a Foley catheter for 1 of 27 residents (Resident #12). Finding include: Resident #20: The Resident was an 81 year old female admitted to the facility on 11/02/05 with diagnoses of atrial fibrillation, Alzheimer's disease, hypertension, and presenile dementia. The resident had a Foley catheter. The careplan for Resident #20 indicated that the indwelling urinary catheter was placed related to a "Left hip infected wound." The goal was "Resident will be free of complications of catheter usage" with a goal date of 5/26/06. The last update noted on the care plan was on 03/30/06. At that time it was noted in the careplan that the wound was healed. There was no plan for the removal of the catheter in the care plan. The catheter was still in place at the time of survey. Another consideration for removal of the catheter after the wound had healed was that Resident #20 was prescribed Coumadin, a blood thinner. Laboratory tests on several occasions revealed high serum levels of Coumadin which increased the likelihood of bleeding should the resident have any type of injury. Should the resident have had an incident of catheter displacement or injury, significant bleeding may have resulted.	F 315	F 315 The facility does and will continue to assess the residents need for a Foley catheter and will assess residents toileting needs following the removal of a Foley catheter. • The Foley catheter has been removed for Resident # 20. The facility is developing a new plan of care for this resident. Resident # 12 has been discharged to home. • Residents with Foley will be reviewed for continued need and the catheter removed and care plan adjusted as appropriate. • Licensed nurses will be educated to the process for evaluation of medical necessity for foley catheters and the process for post removal of the catheter, care planning and implementation of appropriate toileting programs. • Random audits will be conducted by the DON or designee to ensure ongoing re-evaluation of appropriateness of Foley catheter and/or toileting program. Results will be trended and reported to QAA committee on a quarterly basis.	6/19/06 7/9/06 7/9/06 7/9/06

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F 315	Continued From page 23 Resident #12: The resident was readmitted to the facility on 3/30/06. She had been in an acute care facility. Her original admission was 3/10/06, also following an acute facility stay. The resident's diagnoses included deep vein thrombosis, colitis, hypertension, anxiety and a clostridium difficile infection. Due to the bouts of diarrhea, the resident had a Foley catheter. On 3/31/06, an order was written to discontinue the catheter on 4/3/06. Two care plans were present in the record, one for scheduled incontinent care and comfort, and one for indwelling catheter usage. There was no evidence in the record that the facility completed any assessment following the discontinuation of the catheter to determine if the resident was continent of bladder and, if not, was she a candidate for bladder retraining. The facility had a developed tool, the Bladder Patterning and Analysis Worksheet, designed to record voiding patterns. Upon completion of this data, the information could be analyzed to determine if the resident was appropriate for bladder retraining, prompted toileting, or scheduled care and comfort. The record did not contain any consistent documentation of specific data such as frequency and times of incontinency, toileting attempts and responses to the attempts. Neither was there evidence that a care plan for discontinuation of the catheter had been developed. In an interview with the DON on 5/24/06, she indicated that there was a facility care plan for the removal of an indwelling catheter. It contained approaches such as obtaining a resident history of continence management prior to removing the catheter, monitoring with bladder scans, and	F 315		

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F 315	Continued From page 24 beginning three day bladder patterning. There was also a bladder retraining care plan with approaches of identifying the voiding pattern and establishment of daytime toileting times, identification of a voiding schedule and muscle exercises and other alternative interventions to assist in meeting the scheduling goals. The facility also had a care plan for an individualized voiding schedule which identified voiding patterns, reminding the resident to toilet at routine times, and providing assistance with toileting. None of these instruments were present in the resident's record. In an interview with the resident on 5/25/06, she indicated that prior to the onset of her diarrhea and ensuing weakness, there had been no problems with bladder incontinency. She further stated that upon the removal of the catheter, she had been placed in "diapers," and that no toileting program had been initiated. Upon learning that she was to be discharged back to her independent assisted living arrangement, she had taken it upon herself to toilet at frequent intervals instead of voiding into the "diaper." While the facility had a formal procedure with established tools, the facility failed to provide appropriate services necessary to restore as much bladder function as possible.	F 315		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a	F 368		

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F 368	Continued From page 25 substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to ensure that all residents who did not have dietary restrictions were being offered a bedtime snack. Findings include: During the group interview on 5/23/06 several residents indicated that they were not offered a bedtime snack. Some residents indicated that they could ask for a snack. One resident said she was diabetic and was supposed to receive a bedtime snack. The resident said she was not offered a snack and had a family member bring in graham crackers for to eat at bedtime. An interview with the director of nurses revealed that a snack cart was sent to each nurses' station after the evening meal, but that no one was assigned to pass bedtime snacks. The director of nurses did not know if bedtime snacks were being offered to each resident.	F 368	F 368 • The facility does and will continue to ensure that residents are offered a bedtime snack. • Residents residing in the facility will be offered bedtime snacks. • Licensed nurses, CNA's and dietary personnel will be inserviced on this requirement. Dietary Manager will ensure that an adequate number of snacks are available at the nursing units. The CNA assigned to the resident will be responsible to offer their residents a bedtime snack. • Offering bedtime snacks will be added as an agenda item during monthly Resident Council. Problems identified will be addressed at QAA meeting for further recommendations.	7/9/06
F 371	483.35(i)(2) SANITARY CONDITIONS - FOOD	F 371		

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F 371 SS=B	Continued From page 26 PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility failed to ensure that meal trays delivered to residents in their rooms were delivered in a manner that would ensure the maintenance of infection control on two of the three halls of the Wellington wing. Findings include: During a random observation on 5/22/06, the lunch tray cart was delivered to the Wellington wing at approximately 11:45 AM. The cart was positioned at the doorway of an activity room that was next to the nurses' station. The cart was a multi-tray cart with doors that opened on either end. The cart doors were closed. At 12:05 PM, a staff member opened and closed the cart door to remove a tray. The tray was taken to room 89 approximately 30 feet from the cart. At 12:20 PM the cart was opened on one side and a CNA (certified nursing assistant) removed a tray and took the tray to a resident's room. The cart door was left open. At this time it was observed that the hot foods were covered with a metal cover. The beverages that were in drinking glasses and the dessert that was on a small plate did not have any protective wrap or covering over the contents. It was observed that there were 12 trays with	F 371	F 371 • The facility does and will continue to ensure that meal trays delivered to residents in their rooms are delivered in a manner that will ensure the maintenance of infection control. • Residents that eat in their rooms will receive trays with food items covered. • Licensed nurses, CNA's and dietary staff will be educated on infection control practices for hall tray delivery. The nursing staff have been instructed to wheel the food cart from room to room as they deliver the resident trays. • Supervisory staff will be assigned to monitor hall tray delivery on each unit. The supervisory staff will complete the QAA audit tool for dining services. Problems identified will be brought to the Dining Room Committee for further recommendations.	7/9/06 ↓

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F 371	Continued From page 27 prepared meals remaining in the food cart. The closest room to the cart was approximately 15 feet. The furthest rooms were approximately 70-80 feet away. At 12:30 PM both cart doors were opened, there were still seven trays present in the cart. At 12:40 PM it was observed that all meals had been passed. Interviews with two CNAs after meals were passed confirmed that the cart was placed in the hall next to the activity doorway to keep the cart out of the way. Both CNAs confirmed that this was always how trays were passed. An interview with the dietician who was at the Wellington nurses' station during this meal pass stated that the trays should be passed within 15 minutes upon arrival to the nurses station. On 5/22/06 the policy and/or procedure for passing meal trays was requested and was informed that there was not one. The in-service records that dealt with meal tray delivery and infection control were also requested and no documentation of any in-services that included meal tray delivery infection control for the past 12 months was provided.	F 371		
F 431 SS=E	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined that the facility failed to have drugs and biologicals labeled and discarded in accordance with their policy. Findings include: The facility's policy was reviewed for medication expiration. The facility's policy read, "Products commonly dispensed in the manufacturer's original multiple dose containers (i.e., oral liquid antacids and laxatives, cough syrups, creams and ointments) will expire one year after opening. All such containers shall be dispensed with a "DATE OPENED" sticker attached." The policy also stated that "Multiple dose injectables containing preservatives (including insulin) will expire 30 days after opening. All such containers shall be dispensed with a "DATE OPENED" sticker attached." On 05/23/06, at 2:00 PM, an observation of the Wellington medication room was conducted. When asked what the protocol was that they use for medications that were injectables and oral liquids, the staff nurse stated that they should be dated and disposed of 30 days after opening. There were three vials of injectable medications that were open and not labeled with the date opened: Haldol and two vials of Lorazepam. Three bottles of Vit C 600 mg with expiration dates of 4/22/06 were found in the medication room cupboard. These medications were house stock items.	F 431	F 431 The facility does and will continue to label drugs and biologicals in accordance with currently accepted professional principles. • Biologicals identified as being expired or opened and unlabeled have been discarded. • Residents receiving multi dose biologicals can be assured that labeling and attention to expiration date will occur. • Licensed nurses will be educated on the protocol for labeling and monitoring expiration dates and destruction of expired medications. The Pharmacy Nurse Consultant will inspect the medication room and med carts on a monthly basis. A report will be completed and submitted to the DON. • The DON or designee will review the Pharmacy Nurse Consultant report, make corrections as needed and report the findings to QAA committee for review.	6/19/06 7/9/06 7/9/06 7/9/06

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F 431	Continued From page 29 A bottle of oral Sorbitol liquid was open and not labeled with the date opened. On 5/24/06, at 9:30 AM, the medication storage room and the medication carts of Arcadia Hall were observed. The following observations were made: One unopened packet of Ipratropium Bromide Inhalation Solution had expired 2/06. Four unopened containers of Albuterol Sulfate 0.083% had expired 4/06. One opened vial of Novolin R did not include the date it was opened on the label. On 5/22/06, the Kensington medication room was observed. On 5/24/06, the Heritage and Windsor medication carts were observed. The following had expired: Hemoccult specimen cards had expired on 07/05. One vial of Promethazine had expired on 1/06. The following medications were found opened with no open date indicated on the vial: One vial of Humulin N insulin. One tuberculosis skin testing vial. The following medications were dated when they were opened but had gone over the facility's 30 day expiration policy: An opened pneumovax vial had an open date of 12/14/05. An opened vial of insulin had an open date of 4/10/06. An opened vial of insulin had an open date of 11/21/05. At 1:30 PM, on 5/23/06 an observation of the medication room on Stratford Hall was	F 431		

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F 431	Continued From page 30 conducted. Two vials of house stock PPD material for Tuberculosis testing were found. Both vials had been opened but neither vial had been labeled as to when that had occurred. One vial had a manufacturer's expiration date of 5/17/06, while the other vial had expired 5/08/06. On 5/24/06 the medication room and the medication carts for Arcadia Hall were observed. The following medications were found to be past their expiration date: One unopened container of Ipratropium Bromide Inhalation Solution 0.002% expired 2/06. Four unopened containers of Albuterol Sulfate Inhalation Solution 0.083% expired 4/06. One opened vial of Novolin R insulin did not include the date it was opened on the vial.	F 431	F 432 This facility does and will continue to store drugs and biologicals in locked compartments under proper temperature controls. • The Imperial Sysco Thickener was discarded. The morphine was removed from the refrigerator since refrigeration is not required. The morphine is awaiting destruction by the contract Pharmacist and will not be administered to any residents.	6/29/06
F 432 SS=E	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 432	• Resident medications will be stored at the appropriate temperature. The freezers in the refrigerators in the medication rooms are not used. In the event a biological did require freezing, it would be stored in a freezer that would be able to maintain a temperature of 0 degrees F • Licensed nurses will be educated on the correct temperature range for the refrigerators, as well as how to correct a slight discrepancy in the range and ensure daily documentation to meet this requirement. • DON or designee will audit the temperature logs weekly. Problems identified will be addressed immediately and trends reported to QAA committee as needed.	7/9/06 7/9/06 7/9/06

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F 432	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations of medication rooms and medication carts, it was determined that the facility failed to store some biologicals under the proper temperatures or to maintain the recommended temperatures of the medication refrigerators. Findings include: Observation of the locked medication refrigerator in the Stratford medication room revealed that the freezer compartment did not have a door. The lack of a door did not ensure reliable temperature readings for the freezer compartment. A review of the temperature logs for the refrigerator disclosed: An undated temperature log with recorded readings for 13 of 31 one days. A temperature log dated February 2006 with recorded temperatures for 12 of 28 days. A temperature log dated March 2006 with recorded readings for 20 of 30 days. A temperature log dated April 2006 with recorded readings for 16 of 30 days. Only the February page of the temperature log indicated what the temperature range should be for the refrigerator and the freezer. The undated log indicated that on the days that the temperatures were recorded that none of the freezer readings were within the recommended range of zero degrees or below. Six of the recorded temperatures for the refrigerator were outside of the recommended range of 34-45	F 432		

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F 432	Continued From page 32 degrees. There was no documentation that any corrective action was undertaken. In February, there were five days that the refrigerator and the freezer temperatures were not within the recommended range. There were no indications that adjustments were made. In March 2006, there were nine days that the temperatures were outside the recommended range without the needed interventions. In April, there were eight days that no adjustments were undertaken for temperatures outside of the required range for both the refrigerator and freezer. None of the 21 readings recorded for the freezer in May 2006 were the recommended zero degrees or below. There was no evidence of corrective action. On 5/22/06, the Kensington medication room was observed. The refrigerator was found locked. The listed temperatures are in Farenheit. When the refrigerator was opened the temperature was found to be at 48 degrees. According to the facility's refrigerator temperature log the refrigerator temperature should be between 34 and 45 degrees. A review of the temperature log revealed that the temperature had been over 45 degrees in four out of the last 22 days. From the months of January to April the temperature had been over 45 degrees on seven different days. On 5/22/06, vials of morphine sulfate were observed in the locked portion of the refrigerator. A nurse stated that the morphine was locked in the refrigerator because they ran out of room to lock it in the medication cart. According to the	F 432		

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F 432	Continued From page 33 pharmacist morphine should be stored between 68 and 77 degrees, although it could be stored between 59 to 86 degrees. The facility's destruction of medications policy indicated that, "As soon as a medication becomes inactive, the unit charge nurse or designee should remove all supplies of the drug from stock, count the remaining doses, and destroy them. Drugs should not be "stockpiled" for mass destruction." A bin in the Kensington medication room was observed to be full of expired medications. Expired medications for discharged patients were also found on the nearby counter, in the cupboard above the counter, and in the refrigerator. A nurse stated these medications were awaiting destruction by the pharmacy. On 5/24/06, the Windsor medication cart was observed to have a carton of Imperial Sysco Thickener on top of it. The carton was observed to have an open date of 5/23/06. The thickener was observed on the top of the cart on 5/24/06, at 11:00 AM, 1:00 PM, 2:45 PM and on 5/25/06, at 8:30 AM. The instructions on the carton indicated that once the carton was opened it could be stored at room temperature up to eight hours or refrigerated up to five days.	F 432		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as	F 441		

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F 441	Continued From page 34 isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined that the facility failed to establish and maintain an infection control program that analyzed the data on resident infections in order to develop measures to prevent the development and transmission of disease and infection and failed to obtain consent or document the reason that 2 of 27 residents (Residents #7 and #21) did not have pneumonia vaccinations. Findings include: In an interview with the Infection Control Co-coordinator, it was found that this staff person was also the Unit Manager for one of the halls. Data concerning infections in residents was being collected in the facility, however there was no evidence that it was being analyzed. There was no mechanism to monitor and investigate the individual cases. The data did not delineate, by resident, not only the day of the infection but the causative agent, the site of the infection, the treatments involved, if an effective antibiotic was given, if isolation was required, the response to the treatment, and if a reoccurrence occurred. Not all of the components of the data collection were consistent. There was no system in place to ensure that residents were receiving the required two step	F 441	F 441 The facility has established and will continue to maintain an infection control program that analyzes the data on resident infections and will develop measures to prevent the development and transmission of infection. The facility does and will continue to ensure that residents are offered pneumonia vaccinations. • Resident # 7 has been discharged from the facility. Resident # 21 will be offered a Pneumonia vaccine. • Current residents and newly admitted residents that have not already received a pneumonia vaccine will be offered a pneumovax. A resident declination and the reason for declining will be documented. Staff with an infectious illness will continue to notify their supervisor and return to work when their symptoms have subsided. Current and newly admitted residents will receive TB testing, unless contraindicated as statute requires.	6/19/06 6/24/06 7/9/06 7/9/06 7/9/06

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F 441	Continued From page 35 Tuberculin testing upon admission or the mandatory annual testing. There was no accountability for consistency of new employees being skin tested for tuberculosis, measures for screening of the health care workers with communicable diseases, monitoring of employee illnesses or apparent guidelines for work restrictions of ill employees who might be infectious. Cross reference Tag F442. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Resident #7: The resident was a 90 year old female admitted to the facility on 05/11/06 with diagnoses of debility, urinary tract infection, malaise and fatigue and a history of falls. The resident record contained a consent form for pneumonia vaccination that was unsigned by the resident or a family member. Handwritten in the upper right hand area of the form was the phrase "refuses to take." There was no explanation or reason given anywhere on the document for the refusal by the resident. Resident #21: The resident was a 71 year old female admitted to the facility on 05/16/06 with diagnoses of a malignant neoplasm, a peptic ulcer, lumbago, cardiac dysrhythmia, autoimmune disease, and diabetes with no insulin dependency. The resident record contained a consent form for pneumonia vaccination that was unsigned by the resident or a family member either consenting to or refusing the vaccination.	F 441	• Ongoing audit of Medical Records will continue to ensure that pneumonia vaccine has been offered, given or declined, as well as TB testing performed on appropriate residents. Staff will be educated to regulation and process. The infection control program has been reviewed. The infection control coordinator has been educated to the process for evaluation of data collected. Staff attendance policy has been revised and guides employees to notify their supervisor of an infectious illness and refrain from coming to work until appropriate. Staff has been educated to this policy. This will be monitored by the Department Manager and Human Resources. • Random audit will be conducted on an ongoing basis to ensure that TB testing and pneumonia vaccine are delivered in compliance with regulations. Deficiencies will be corrected immediately and trends will be identified and brought to the QAA committee for further recommendations.	7/9/06 7/9/06

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F 443	Continued From page 36	F 443	The infection control coordinator will complete a monthly summary and analysis of infection trends in the facility and report findings to the QAA committee for further recommendations as needed. The Human Resource Director will provide a summary of employee illness monthly to the QAA committee.	7/9/06
F 443 SS=D	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide a mechanism that would ensure the prevention of the transmission of communicable diseases from the employees to the residents. Findings include: Review of the Infection Control Log and interview with the Infection Control Co-coordinator failed to establish that any system existed for documenting and monitoring employee illnesses. In an interview with the Infection Control Co-coordinator on 5/24/06, she acknowledged that she did not consistently track employee illnesses. Such a system is necessary to prevent the spread of any communicable disease or illness from the sick employee to the residents. Cross reference to Tag F441.	F 443	F 443 The facility does and will continue to ensure the prevention of transmission of communicable diseases. • The facility will ensure the prevention of the transmission of communicable illnesses from the employees to the residents. Employees with an infectious illness will refrain from attendance at work until symptoms are absent. Cross reference 441	7/9/06
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	F 444		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation of staff and policy review, it was determined that the facility failed to ensure that staff washed their hands during wound care procedures in accordance with the facility's policy and procedure for two non-sampled residents. Findings include: On 05/23/06, at 9:20 AM an observation of wound care was conducted on the Wellington Unit. The LPN did a dressing change to a resident's coccyx decubitus. The nurse was observed to wash her hands before the procedure and after the procedure. She used only one set of gloves throughout the entire dressing change for resident. She removed the dressing, cleansed the wound, and applied the new dressing without changing her gloves or washing her hands again. The soiled dressing that was removed was initially placed on the bedside table. It was then disposed of in the garbage can next to the resident's bed. Observation was done for another resident's leg wound. Following the removal of the soiled dressing, the nurse did not change her gloves or wash her hands between the cleansing and dressing of the wound. Review of the facility policy revealed instructions to "Remove non-sterile gloves and discard in trash bag, wash hands" after removal of soiled dressing.	F 444	F 444 The facility does and will continue to ensure staff wash their hands after each direct resident contact. • The facility will ensure that staff wash their hands after each direct resident contact where handwashing is indicated by acceptable professional practice. • Residents with wounds will receive care as per standards of practice for handwashing during wound care . • Licensed nurses will receive education on the standards of practice concerning hand washing during wound care. • Nurse managers will randomly observe Licensed Nurses performing wound care in compliance with the standards of practice concerning handwashing during wound care. Additional education will be provided as needed. Trends reported will be reported to QAA for further recommendations.	7/9/06
F 492 SS=E	483.75(b) ADMINISTRATION The facility must operate and provide services in	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	05/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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F 492	Continued From page 38 compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that all employees working with residents received eight hours of dementia training within the first 30 days of hire in accordance with Nevada Administrative Code Chapter 449. Findings include: A review of the personnel files for Employees #1, #2, #5, and #9 revealed that there was no documented evidence of dementia training as required by state law. There was no evidence that licensed nurses, physical therapists, activity personnel, or occupational therapists were receiving dementia training.	F 492	F 492 The facility does and will continue to ensure that employees working with residents receive dementia training. • Employee # 2 had completed dementia training, but the certificate was not brought forward to new personnel file when she was rehired. Employee # 1 had completed three of the eight modules of dementia training and is scheduled to completed these modules. Employee # 5 is the DON who teaches the dementia training and this training program was reviewed and approved by the Nevada State Board of Nursing in 2004. The DON is an approved CE provider in the state of Nevada. Employee # 9 is scheduled to complete dementia training. • Residents with dementia are cared for by staff who have had dementia training. • The facility does and will continue to offer eight hours of dementia training monthly as well as three hours of related topics annually.	7/9/06 7/9/06 7/9/06
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		

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F 514	Continued From page 39 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to maintain the clinical records that were complete, accurately documented, readily accessible, and systematically organized for 3 of 27 residents in the sample (Residents #23, #3, and #12) and 1 unsampled resident. Findings include: Resident #23: Record review of 5/23/06 revealed that the physician orders did not contain evidence of a verbal order for Haldol. A nurses note of 5/17/06 indicated that the nurse received "new orders for Haldol by mouth (PO) or intermuscular injection (IM) every 2 as needed/agitation." The nurse did not indicate the dosage on the note or the physician who gave her the verbal order. The resident's medication administration record revealed an order for Haldol 1 mg PO/IM for agitation as needed, but did not indicate the date the order was initiated. The DON (Director of Nurses) was interviewed and provided a facility policy which indicated, "a physician order form is completed for each telephone order received." A medication pass observation 5/23/06 revealed that one drop of Travatan 0.004% ophthalmic solution was administered into the left eye of an un-sampled resident. Upon review of the physician's orders for May 2006, the order	F 514	• Human Resources will audit employee files to ensure dementia training is current. Administrator and Department Managers will ensure that employees complete dementia training in order to continue their employment. 7/9/06 F 514 The facility does and will continue to maintain clinical records in accordance with accepted standards. • Consent was obtained and order written for Resident # 23. 6/19/06 Resident # 12 has been discharged from the facility. The order for the unsampled resident eye drops was clarified on 5/25/06. • Current and new residents can be assured that standard documentation procedures will be followed. 7/9/06 • Only staff members designated by Medical Records will have the authority to thin charts according to company policy. 7/9/06 The Pharmacy will provide the facility a list of therapeutic interchanges and indicate when an exchange has occurred. 7/9/06	

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F 514	Continued From page 40 indicated that one drop of Xalatan 0.05% ophthalmic solution was to be administered into the left eye. The Medication Administration Record (MAR) also indicated that the medication was to be Xalatan. Review of the medical record revealed that the resident had been ordered Xalatan 0.05% on 12/15/05. An order from the pharmacy and signed by the physician on 2/11/06 documented that a substitution for specific therapeutic interchange was to be instituted. The substitution was to start Travatan 0.004% ophthalmic solution, one drop to the left eye every morning when Xalatan supply was finished. Review of the Feb, March, April, and May MAR's and the March, April, and May physician's orders revealed no documentation for the therapeutic interchange of Xalatan and Travatan. An interview with the Director of Nursing on 5/23/06 revealed that the facility did not have any record of what drugs were therapeutic exchanges nor did the facility have any reference material in the front of the MAR book or at the nurses station for this drug exchange. Resident #3: An interview with the physical therapist on 5/25/06 for the purpose of tracking the therapy assessments and interventions revealed that the second page of the assessment dated 11/9/05 was missing from the chart on the unit. An interview with the DON (Director of Nursing) and Medical Record staff was conducted on 5/24/06. The DON stated that medical records thinned the charts according to standard	F 514	Licensed nurses have been educated to this protocol. CNA's will be re-educated to the necessity of completing ADL flow sheets daily. TB records have been clarified to include lot number, results and if 2nd test administered and the results. Licensed nurses have been re-educated to the process of obtaining and completing a telephone order form for each order received. Licensed nurses have also been re-educated on the critical nature of accuracy in documentation. • Random audits will be made by DON or designee of ADL sheets for completion. Medical Records will conduct random audits to ensure charts are thinned correctly. The DON will complete random audits to ensure that documentation of therapeutic interchanges is correct and complete. The above reports will be provided to the QAA committee on a quarterly basis for further action as needed.	7/9/06 ↓ 7/9/06 ↓

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F 514	Continued From page 41 procedures. The medical records staff acknowledged that thinned contents of charts are often brought to medical records and are filed without verifying that the information in the thinned contents should have been removed from the charts. Resident #12: The resident was readmitted to the facility on 3/30/06. She had been in acute care. Her original admission was 3/10/06, also following an acute care stay. Diagnoses included deep vein thrombosis, colitis, hypertension, anxiety and clostridium difficile (C-diff). The resident had been diagnosed with several episodes of c-diff, yet the March activities of daily living (ADL) worksheet section for bowel movements lacked documentation for one night shift, two day shifts and four evening shifts. A review of the Tuberculosis Summary Record lacked the following data for the baseline testing: The lot number of the testing material, The results of the initial skin test, and If the second skin test was administered and the results Documentation contained in the Interdisciplinary Progress Notes made it difficult to determine if the resident had a Foley catheter or not. Charting for 4/3/06 stated that the Foley was discontinued per orders. Later that day, it was stated that the Foley was draining clear amber urine. Notes for 4/4/06, charted that the resident was incontinent of bowel and bladder, but on 4/6/06, it was noted that the Foley was patent and to down drain. On 4/7/06, incontinent care was given, but on 4/9/06 the catheter was draining clear amber urine. In an interview with the MDS Co-coordinator on 5/23/06, it was confirmed that the Foley catheter	F 514		

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F 514	Continued From page 42 had been discontinued on 4/3/06. It was found in review of many resident records, that current and pertinent data had been thinned from the records. When the Medical Records Director was interviewed on 5/24/06, she stated that her department attempted to evaluate records for thinning approximately every six months but that currently the department was behind in that task. Their policy was to leave three months of activities of daily living (ADL) sheets, medication administration record (MARS), treatment administration record (TARS), progress notes and other documentation in the active record. She further stated that there were too many others, outside of her department, involved in the thinning process. On occasion thinned data would be left in their department for filing in a thinned record. Their practice was not to check the data for dates or documentation type but to simply file it away.	F 514		

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 29 5043	HCR Manor Care	* K4 5/23/06 / 5/24/06

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING _____

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 [ ] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ] 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: [ ] 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ] 1 PROMPT 2 SLOW 3 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

ENTER E – SCORE HERE

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. [X] (COMP. WITH ALL PROVISIONS)
A2. [ ] (ACCEPTABLE POC)
A3. [ ] (WAIVERS)
A4. [ ] (FSES)
A5. [ ] (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

* MANDATORY